MEDICAL HEALTH HISTORY QUESTIONNAIRE

Name _____ Date _____

Sex M F Birth date _____ Age _____ Phone # _____

Physician's Name _____

Physician's Phone # _____

Person to contact in Case of Emergency Name _____

Phone # _____ Relationship _____

Are you taking any medications or drug? If yes, list: Name, Reason, Dosage etc.

_____

Are you allergic to any medicines? List. _____

Briefly describe your exercise program now.

_____

Do you now, or have you had in the past:	Yes	No
1. History of heart problems, chest pain or stroke.	____	____
2. Increased blood pressure.	____	____
3. Any chronic illness or condition.	____	____
4. Difficulty with physical exercise.	____	____
5. Advice from physician not to exercise.	____	____
6. Recent surgery (last 12 months).	____	____
7. Pregnancy (now or within last 3 months).	____	____
8. History of breathing or lung problems.	____	____
9. Muscle, joint, or back disorder, or any previous injury still affecting you.	____	____

10. Diabetes or thyroid condition. ____ ____

11. Cigarette smoking habit. ____ ____

12. Obesity (more than 20 percent over ideal body weight). ____ ____

13. Increased blood cholesterol. ____ ____

14. History of heart problems in immediate family. ____ ____

15. Hernia, or any condition that may be aggravated by lifting weights. ____ ____

16. Please explain any yes answers on back.

Comments

_____
_____
_____
_____

Do not write below this line

EXERCISE CARD INFORMATION: AGE _____ MAX HEART RATE _____

TARGET HEART RATE ZONE _____ (60 - 70%) THRZ

ATYPICAL INFORMATION _____

PRECAUTIONS/CONTRAINDICATIONS _____
_____

MEDICATIONS _____